Rhode Island Pediatric Primary Care Relief Program Application

Prior to beginning the application, please read the program guidance available at http://www.eohhs.ri.gov/Initiatives/PediRelief.aspx. To complete this application, you will need:

- The practice's Tax Identification Number (TIN)
- The practice's National Provider Identifier (NPI) (also referred to as a Type 2 NPI or Group NPI).
- The practice's D-U-N-S (Data Universal Numbering System, or DUNS) number, if it has one. If a practice does not have a DUNS number, one must be obtained prior to application. The practice can obtain one for free at this link: https://www.dnb.com/duns-number/get-a-duns.html. .
- The names and National Provider Identifier (NPI) numbers for each clinician with credentials MD, DO, NP, or PA who manages a patient panel at the practice site.
- The number of active patients as of May 31, 2020 who are children under the age of 18. Active patients are defined as those patients who have been served by the practice over the last two years: June 1, 2018 – May 31, 2020.
- Bank account information for electronic funds transfer.
- Completed IRS Form W-9 if the practice is not enrolled in the Medicaid Fee-for-Service Program. This form must be emailed to EOHHS at OHHS.PediRelief@ohhs.ri.gov.
- Completed Immunization Quality Improvement Plan

Payments will be processed by the Medicaid Management Information System (MMIS). You will be asked to report a Medicaid Legacy Provider ID if the practice has one. If you are not currently registered as a Medicaid Fee-for-Service provider, the state will register you for the purpose of processing payments under the Pediatric Primary Care Relief Program. This will not result in you becoming a Medicaid Fee-for-Service provider. You may receive an IRS Form 1099 from the State of Rhode Island.

Incomplete applications will not be accepted. If you have questions about this application, please contact OHHS.PediRelief@ohhs.ri.gov.

Contact Information

1. Please fill out your contact information.
    a. First Name
    b. Last Name
    c. Title
    d. Email Address
    e. Phone Number

Practice Information

2. Please fill out the following information for the practice seeking participation in the program.
    a. Legal Name of Practice

b. DBA, if applicable
c. Street Address
d. City
e. State
f. Zip + 4
g. Federal Congressional District
h. Site Contact Person's Name
i. Site Contact Person's Email Address
j. Phone Number
k. Fax Number
l. Address for principal place of performance of grant funded activities in Rhode Island, if different from prior address
m. Street Address
n. City
o. State
p. Zip + 4
q. Federal Congressional District

3. What is the Tax Identification Number (TIN) for this practice?
4. What is the National Provider Identifier (NPI) for this practice?
5. What is the D-U-N-S (Data Universal Numbering System, or DUNS) number for this practice (if it has one)?
6. How many full-time equivalent clinicians with the credential MD, DO, NP, or PA manage a patient panel at this site?
7. For each clinician with the credential MD, DO, NP, or PA managing a patient panel at this practice site, please list the clinician's first name, last name, and National Provider Identifier (NPI) number.
8. Which of the below specialties best indicates the primary care specialty of the practice?
    a. Family Practice
    b. Pediatric Practice
    c. Other (please specify)
9. Please report the number of active patients as of May 31, 2020 who are children under the age of 18. Active patients are defined as those patients who have been served by the practice over the last 24-months.
10. Is this practice currently enrolled in the Medicaid Fee-for-Service Program?
    a. Yes or No
    b. If Yes, please provide the practice's Legacy Provider ID.
    c. If No, please submit IRS Form W9 to EOHHS by emailing OHHS.PediRelief@ohhs.ri.gov and including ATTN – W9 in the subject line of the email. In the email please include the practice name, address, and Group NPI.
11. The State will need banking information to provide for electronic funds transfer. Please provide the following information to support timely payment.
    a. Bank Name
    b. Is this a checking account or a savings account?
    c. Bank Routing Number
    d. Bank Account Number
12. Attachments

    a. Attach Immunization Quality Improvement Plan

b. Attach Signed Financial Agreement

13. Financial Reporting: Please report the following financial information.
    a. Method of accounting (cash/accrual)
    b. Gross revenues (most recent complete fiscal year)
    c. Fiscal year of gross revenues
    d. Percentage of gross revenues from patient care
    e. Gross revenues from March, April, and May 2019
    f. Gross patient care revenues from March, April, and May 2019
    g. Gross revenues from March, April, and May 2020
    h. Gross patient care revenues from March, April, and May 2020
    i. Lost revenues due to COVID-19
    j. Increased expenses due to COVID-19
    k. Total amount received from CARES Act Provider Relief Fund
    l. Total amount received from Paycheck Protection Program loan
    m. What date was your Paycheck Protection Program loan disbursed
14. FFATA Information:
    a. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenues in U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements? Yes/No
        i. If no, skip the remaining two questions.
    b. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under Section 13(a) or 15(d) of the Security Exchange Act of 1934 (15 USC 78m(a), 78(o(d)) or Section 6104 of the Internal Revenue Code of 1986? Yes/No
        i. If yes, skip the next question.
    c. List the name and total compensation amount of the five highest paid executives in your business or organization. A definition of total compensation is available at this site.

Attestation

By submitting this application for the Rhode Island Pediatric Primary Care Relief Program, I acknowledge that I am authorized to submit this request on behalf of the provider/practice and that all of the information provided is accurate to the best of my knowledge and ability. I acknowledge the State of Rhode Island is relying upon the information as submitted in order to determine whether to issue a Rhode Island Pediatric Primary Care Relief Program payment. Therefore, if I become aware of any inaccuracies in the information provided, I will immediately notify the State of Rhode Island through email at OHHS.PediRelief@ohhs.ri.gov.